

Informing Best Practices for Children in Psychiatric Crises: Perspectives and Insights From Families

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ABSTRACT

Young children in psychiatric crisis present complex challenges to their families and service providers. This article presents a qualitative study of families' perspectives on the crisis that led to their child's hospitalization, as well as their experience and satisfaction with prior community-based services including crisis services. Results of the study support the usefulness of an ecological view on child mental health emergencies, and specify the need for the development of a more family-centered, community-based crisis response system that includes secure transportation and access to "warm-line" services. To prevent or curtail hospitalization of children, families require assistance in outpatient medication management, especially timely access to psychiatric medication consults and clear information from professionals about benefits and side effects.

As part of a continued effort to reduce the admission of children in psychiatric crisis to inpatient facilities, community-based mental health services today are expected to provide an array of crisis services for children and families (U.S. Department of Health and Human Services, 1999). Effective crisis services for young people must be able to meet the needs of children who are affected by a single traumatic event or repeated trauma, as well as those with long-term chronic emotional and behavioral problems who experience periodic episodes of acute crisis (Burns, Hoagwood, & Mrazek, 1999). Because many youth enter mental health services at a point of crisis, the purpose of quality crisis services includes the provision of immediate evaluation and assessment, sufficient care to stabilize the crisis situation, as well as opening the door for longer-term services within the mental health system to prevent further crises (Burns et al., 1999). Types of services can include telephone hotlines, crisis group homes, walk-in

services, runaway shelters, mobile crisis teams, and therapeutic foster homes, if used for short-term crisis placements, as well as crisis stabilization units, hospital emergency rooms, and inpatient services (Burns et al., 1999; Kutash & Rivera, 1995; Stroul & Goldman, 1990).

While this entire array of services is usually not available in all communities, a survey of 32 home-based programs by Stroul and Goldman (1990) found that community-based crisis services shared common characteristics such as: the availability to provide screening, evaluation, intervention, and support 24 hours per day, 7 days per week; a purpose to avert hospitalization if appropriate and stabilize the situation in the least-restrictive appropriate setting; a short-term focus (4–6 weeks) using the time limitations and the increased willingness of clients to initiate change; integration of crisis services with other longer-term treatment options; a dual focus on identifying and prioritizing precipitating factors, as well as mobilizing youth and fam-

ilies to develop new ways of coping; and an intent to maximize involvement of immediate and extended families in all phases of treatment.

Taking a multi-dimensional approach to understanding “best practices” (Petr & Walter, 2005), this article specifically honors the perspectives and experiences of families with children in psychiatric crisis. Results of a multiple-case study that involved qualitative interviews with 12 families, whose children ages 12 years old or younger were admitted to a state hospital in Kansas, highlight the circumstances of families’ crises, and families’ experience and satisfaction with community-based services including crisis services. Results lend credence to an ecological framework for understanding psychiatric crises in children cogently outlined by Pumariega and Winters (2003). The framework is briefly summarized in the following paragraphs.

Best Practices for Children in Psychiatric Crises: Current Knowledge

Empirical Studies of Programs

To date, the empirical base for understanding how community-based crisis services can be most effective for children and youth with serious psychiatric symptoms is still very limited. Even more sparse are studies inquiring directly into the experiences and needs of families with children in psychiatric crises. With the exception of experimental studies about multisystemic therapy (Henggeler et al., 1999; Schoenwald, Ward, Henggeler, & Rowland, 2000; Henggeler, Schoenwald, Rowland, & Cunningham, 2002; Henggeler et al., 2003), and a comparative study about three intensive in-home programs in the Bronx, New York (Evans et al., 1997, 2001, 2003), the current evidence base for the effectiveness of crisis programs for children and adolescents consists largely of uncontrolled studies or program descriptions (Blumberg, 2002; Gutstein, Rudd, Graham, & Rayha, 1988; Sawicki, 1988; Stelzer & Elliott, 1990; Silver & Goldstein, 1992).

Overall, most of these studies demonstrate some potential of crisis intervention programs to divert youth from institutional placements but also indicate the need for further research to explore differences between crisis-oriented, home-based services, and other types of community-based crisis services, and their respective outcomes and cost effectiveness (Burns et al., 1999; Kutash & Rivera, 1995; Pumariega & Winters, 2003). At least for a short-term period, crisis programs can bring about improvements in behavior, diminished suicidal tendencies, and increases in self-concept for some children or heightened parental self-efficacy. However, it appears that the gains children with serious emotional disorders (SED) initially make on behavioral scores, self-concept, or other measures will dissipate after the intervention ends and pre-existing chronic difficulties will continue (Evans et al., 2003; Henggeler et al., 2003). Therefore, crisis programs

alone seem insufficient to maintain gains beyond the end of intervention unless “booster” services or ongoing supports are employed, or crisis services are fully integrated into a continuum of care ensuring the continuity of services with an appropriate intensity.

An Ecological Framework for Child Mental Health Emergencies

Pumariega and Winters (2003) suggest that child psychiatric emergencies are best understood in their ecological context. The authors point out that the occurrence of a crisis for a child is determined by the timing of a child’s behaviors and the resources available to adults.

Generally, a child’s parents or other responsible adults decide when the child’s emotional or behavioral problems are beyond their control and require emergency services. The timing of the acute presentation is as likely to result from impairment in the adult’s functioning (or capacity to contain the child’s behavior) as from a worsening of the child’s psychopathology. (p. 779)

The authors distinguish six types of child mental health crises that may occur concurrently: (1) danger to self or others; (2) danger to the child from others; (3) the child is unable to maintain his or her own safety and use environmental supports; (4) the child engages in serious drug or alcohol use or abuse that endangers his or her own life or that of others; (5) severe environmental stressors adversely impact the family system and render the child vulnerable to heightened stress; (6) environmental supports (i.e., family, community, services) break down and are unable to provide critical safety or support for the child. Contributing contextual factors include the child’s innate vulnerability; the child’s degree of exposure to drugs and alcohol; the family’s psychosocial functioning; adequacy of physical, educational, and financial resources; resources of the extended family, kinship, network, or community; and the adequacy of formal community-based services to ameliorate previous factors.

In the absence of an organized family-oriented system of care, hospitalization and adult-style crisis services focused on screening for hospitalization become the default mode, even though there is “little evidence that hospitalization lowers the risk for subsequent crises, perhaps related to its emphasis on the child’s psychopathology rather than the family and systemic contextual factors implicated in the crisis” (Pumariega & Winters, 2003, p. 780). Common barriers and challenges to successful implementation of community-based crisis services for children include practitioners’ lack of crisis intervention skills and a preference for the comfort and safety of their offices, a lack of adequate resources for emergency medical evaluations or available psychiatric hospital beds, and the need to integrate medical and developmental perspectives

into community-based crisis intervention approaches. In addition, the implementation of managed care principles, typically designed for adult needs, and regulations about medical necessity do not easily fit strength-based, family-centered, and ecological models.

Research on Family Perspectives and Experiences With Crises

An ecological view of contributing and protective factors for crises is supported by two qualitative studies about the experiences and perspectives of parents with children in psychiatric crises (Petr, 1994; Sharer, 2002). A focus group study by Petr (1994) explored the perspectives and experiences of families trying to cope with crisis situations that threatened out-of-home placement for children. Multiple interviews in 6-month intervals were conducted with 10 families whose children were diagnosed with emotional and behavioral disorders. All families had experienced at least one major crisis threatening out-of-home placement, and four children were placed out of the home.

The author distinguished four types of crisis precipitating events: (1) system-induced; (2) child condition or behavior, (3) parent incapacity, and (4) general stress. Results indicated that informal supports and support groups were vitally important for families to cope successfully. Spouses, friends, and extended family were the first support systems sought out by families; respite care and parent support groups were viewed as useful concrete supports. Families also benefited from services focusing on the prevention of crises rather than mere crisis intervention. Conventional family preservation or short-term crisis intervention models did not seem successful for these families of children with serious emotional and behavioral difficulties. Families and children needed more sustained supports including medical insurance, counseling, respite care, special education, and vocational training, all of which could help prevent crises situations. In turn, the absence or discontinuance of such ongoing services can precipitate crises. The author also found that attitudes and values of professionals made a difference in that competent, non-blaming, strengths-focused service providers who formed long-term alliances were treasured by families. Labeling families as dysfunctional and other disrespectful attitudes led families to experience professionals as adding to the stress rather than relieving it. Although psychotropic medication for children remained a controversial issue, for many families, properly prescribed, administered, and monitored medications were critical in keeping the child at home (Petr, 1994).

A qualitative study by Sharer (2002) elicited parents' descriptions of what they wanted and needed from mental health professionals prior, during, and after hospitalization. The study involved 38 parents of 29 hospitalized children between the ages of 5 and 12 years old and found three main categories of families' needs and

wants: (1) accurate, honest, and timely information; (2) instrumental support; and (3) emotional support. Parents requested accurate, timely, and honest information about the child's diagnosis, problems, and prognoses; the workings of the hospital unit; and how to identify and access available community services. Because their ability to remember and process information was limited during times of crises, parents preferred that information be given both verbally and in written form. Desires for more instrumental support included having easier access to the child in the hospital, which was particularly difficult for families in rural areas who were required to travel long distances; more opportunities for rooming-in arrangements; and flexible visiting hours. Various parents found that adequate and available outpatient services were lacking or they felt dismissed by mental health center staff who appeared to regard parents' view of the crisis as inflated. Many parents reported being isolated in their communities due to their child's difficulties and looked to unit staff and other parents for emotional support (Sharer, 2002).

The Study

The following study was part of a larger evaluation of the appropriateness of young children's admissions to state hospitals in Kansas (Walter, Davis & Petr, 2005). Results of this multiple-case study lend insights into the perspectives of families with children in severe and chronic mental health crises. In order to gain a rich understanding of the circumstances surrounding the admission of children to hospitals, qualitative interviews elicited parents' experiences of the crisis and community-based services preceding their child's admission. As part of community-based services, community mental health centers in the state under study are required to offer crisis services and mandatory screenings through crisis team staff to determine the need for hospitalization prior to admission.

Data Collection and Analysis

Participants were recruited from a convenience sample of families with children age 12 years old and under who were admitted to or residing at state mental hospitals in Kansas during the months of November 2004 through January 2005. Twelve families agreed to participate. Their children ranged in age from 6 to 12 years old; boys were the majority (66.6%), and all but one were Caucasian.

All of the children had a significant history of chronic and severe psychiatric difficulties. Primary diagnoses of the sample included mood disorder, bipolar disorder, post-traumatic stress disorder (PTSD), reactive attachment disorder (RAD), oppositional defiant disorder (ODD), attention deficit disorder (ADD/ADHD), psychotic disorder, obsessive compulsive disorder (OCD), and autism/pervasive developmental disorder (PDD). All of

the children in the sample carried multiple psychiatric diagnoses at the time of admission to the hospital.

Feedback elicited from staff at the state psychiatric hospitals and family advocates in the state confirmed that children in the sample were indeed similar to the larger population of children admitted to state hospitals in terms of demographic data and diagnostic information. A comparison of the sample to data available for the population of children admitted to the same hospitals in the preceding fiscal year allowed for the same conclusion.

After families consented to participate in the study, two researchers met with family participants to conduct a face-to-face interview. A total of 13 family interviews were conducted reflecting the responses of 10 biological, adoptive, or foster mothers; 2 fathers; and 2 aunts who functioned as main caretakers at the time of the crisis. All interviews were audio-taped, transcribed for analysis, and entered into a qualitative data base (Atlas.ti) for coding and data management. While family interviews were conducted jointly, each researcher took primary responsibility for six cases. To enhance trustworthiness of the findings (Lincoln & Guba, 1985) the study elicited “thick descriptions” (Geertz, 1973) of the phenomena, and each researcher independently coded and analyzed one pilot case for which she had taken primary responsibility. After subsequently developing a joint coding guide, researchers also served as second raters on each others’ interviews, checking, clarifying, and adding to the first rater’s coding to ensure dependability and confirmability of results.

Results: The Crisis in Context

The Crisis Leading to Hospitalization

At the point of crises that led to hospitalization, all of the children in the study showed some kind of violent behavior directed at self or others, or made threats to harm themselves and/or others, including stabbing themselves with sharp objects, threatening to kill teachers or family members, running in front of moving cars, destroying property, punching and kicking adults or peers, trying to suffocate self, running away from home or school, and so on. Variations of these dangerous behaviors typically occurred both at home and at school, and in 7 of the 12 cases families indicated that difficulties at school were directly related to the most recent hospitalization. The following sections discuss the main themes that emerged from the interviews.

Adjusting or Monitoring Medication

Difficulties adjusting or monitoring medications appeared to contribute significantly to the crisis situations, and were cited as a main reason for hospitalization in nine cases. Families specifically identified a need to have their children’s behaviors and medication side effects monitored by professionals in the wake of medication changes

or adjustments or wanting to take a child temporarily off all medications (“med wash out”). All children in the study received prescribed psychotropic medications before admission to the hospital, making medications the only form of mental health treatment that was received by all children in the sample. Medications were typically prescribed by psychiatrists in the community, but a lack of timely access to psychiatric consults interfered with successfully monitoring effects on an outpatient basis.

History of Psychiatric Difficulties

Children’s acutely dangerous or threatening behaviors occurred in the context of already existing emotional and behavioral difficulties for the child and/or for the family resulting in frequent if not chronic crises. Ten of the children had been hospitalized before, most of them multiple times. In all cases, children had some contact with local community mental health centers prior to admission. Eight of the children in the sample had an Individualized Education Plan (IEP), and three were in structured special education programs with mental health supports for part or all of the school day. Three children were actively served by the child welfare system at the time of admission.

Life Changes or Transitions

In all cases, participants reported that the child and/or family had undergone significant life changes or transitions in the months prior to hospitalization. In seven cases, the child had recently changed schools, seven children had moved, and three had changed main caregivers. Other losses or changes included loss of family members to death, separation or divorce, or final termination of parental rights, changes in schedule and availability of key caregivers (such as a parent entering school, new stepparent, new siblings, foster sibling leaving home, illness in the family, etc.).

Crisis Response

Overall, families were not pleased with the quality and quantity of crisis services they received prior to hospital admission. Faced with children’s violent or otherwise dangerous behaviors at the time of the crisis, families most often contacted, or attempted to contact, a specific mental health provider with whom they had an existing relationship, usually a case manager or therapist. Other contacts were initiated through hotlines, walk-ins at crisis clinics, or in the context of already scheduled meetings. In one case, school personnel initiated the crisis call. Ten families reported they had used a crisis hotline number and found that hotline services worked well in situations with behaviors in which parents could transport the children to the mental health center or to other locations for a screening but were not helpful in resolving an immediate crisis with a child’s violent or dangerous behaviors. Some families reported that hotline responders told them to “call back

during business hours,” or felt dismissed by hotline responders because the child was not deemed homicidal or suicidal. It appeared that the families’ definition of a crisis did not match the definition held by responders.

Well, those people say, “Is he homicidal?” “No.” “Is he suicidal?” “No.” ... “We aren’t going to do anything about that.” So I always felt like my hands were tied, and I felt stupid most of the time. I didn’t know who to turn to, what to do.

Some parents indicated they wanted coaching about how to handle a child’s behaviors, and reported being irritated by hotline responders telling them to call the police.

The center has a crisis line that is a joke. You call it, and you get someone who does not know your child asking you all these questions that are not relevant. In addition, you can tell the person on the other end knows nothing about kids. They tell me to call the police. I am not going to call the police I need some coaching. It’s more useful just to call my parents ... and this is what I do. They come to help when I need them to.

Say you call and have been with the [children] all weekend and need help, and they basically relay, “Well, what do you want us to do? Call the police!” I am sorry, I don’t want to call the police. They will take a totally different approach. Besides, we have had the police out here before and word in town gets around real fast in this rural community.

In 8 of the 12 cases, police officers were involved as part of the crisis response to homes or schools. While the use of law enforcement officers was common practice some families voiced uneasiness with the appropriateness of police involvement.

I couldn’t get a hold of anybody, and so I called the police to get him. They tried to talk to him, and he wouldn’t talk to them, so they had to restrain him and take him.

What is the purpose of arresting special needs children? ... They need to start working with them more intensively in the schools. The paraeducators don’t know what to do—they don’t have directions so they call the police. That is not right.

Participants indicated that crisis plans, a required component of community mental health treatment plans, were most often vague. Rarely could families recall concrete details of a crisis plan other than to call the case manager, the hotline, or the police.

Oh, there was always discussion of crisis plans in court, in wraparound. Let me just say: I’ve never seen one.

Only in one case did providers come to the family’s home to try and assist in the immediate crisis leading to hospitalization. Mobile crisis teams at the community mental health center (CMHC) most often only dispatched a team member to conduct the required pre-admission screening.

Screening and Admission

Asked about their experiences of the screening and admission process, most family respondents indicated that the process was lengthy, exhausting, and often frustrating. Screenings to determine the need for inpatient treatment in a state facility were initiated by case managers, crisis teams, or other mental health professionals, and typically took place in an agency setting such as the community mental health center, juvenile intake at the jail, or hospital emergency room (ER). Institutional locations for screenings were preferred by agencies because of concerns about screener safety, the need for access to communication devices like fax machines and phones to arrange for admission, and easier access to existing records of the child at local CMHC if screenings occurred there.

Transportation to the screening location and/or to the hospital was provided by families themselves, by the CMHC staff, by child welfare providers, by secure transport companies, or by police. Safely transporting the child posed a problem when families did not have their own means of transportation or felt uncomfortable transporting an out-of-control child.

We called them the night before, the crisis team. And they said, “Well, we could send the police to pick her up, but you’re going to have to find your own way there.” And this is like 11:30 at night, you know, half the people in here were already asleep, at least the ones with cars.

So they gave her a shot. There was more [sedatives]. They promised me that she would be asleep in 20 minutes. Well, she finally went to sleep 40 minutes later. And every time you would move her or anything like that, she would wake up and she would fight. So at that point, I was still unsure if I had a bump in the road or something, if I wanted to take her in my car.

Several families described lengthy waiting periods and additional delays because there was miscommunication between players, the screener on-call was busy with other screens, or they had to wait for the hospital to confirm an admission. Using the ER as an entry point tended to lengthen the process further due to added waiting periods caused by

additional paperwork, priority of incoming emergency cases, and procedures, such as required doctor-to-doctor calls before transferring a child out of a medical facility.

We were [at the hospital ER] for like about an hour and a half before [the screener] even showed up because nobody had informed him that we were there yet. Since we had to go through the emergency room, there was a long wait in the emergency room. ... We went up there at, it was between 8:00 and 9:00 a.m. And we didn't get out of there until about 2:00 or 3:00 in the afternoon.

For children in state custody, the admission process was further complicated when procedures and policies to coordinate admissions between the mental health and child welfare systems were unclear to the persons involved, or child welfare agency workers were not readily available to arrange for court orders and signatures on hospital admission paperwork.

I filled out 5 hours worth of papers. And I did all that. And then it came down to "wait, you're not his guardian, this is all null and void." So they had to send the papers or fax them, to the [child welfare agency] to get them signed. ... So I spent all that time, and it frustrated me, I was thinking: [the child welfare agency] knew that. Why weren't they there?

Prior Community-Based Services

All children in the sample received prescribed psychotropic medication, and families frequently voiced concerns about the management of medications and their side effects on an outpatient basis and the lack of timely access to psychiatric consults, especially in rural areas. Some families expressed that psychiatrists did not seem to validate their experience or listen to them, that there was a lack of information about medication interactions, and inconsistent or conflicting recommendations from different providers regarding the appropriateness of given medications.

You know, you've got some doctors that say, "Well, these kids should never be on these meds," and then this doctor here says, "Oh, yeah, we can put him on this, no problem!" ... So who do you believe?

Ten families received an array of community-based mental health services at the time of hospitalization. Aside from medication services, case management was the most utilized service, and families voiced the greatest satisfaction about the services provided by case managers. The nine families who received case management felt supported, listened to, and relayed that their children related well with case workers.

She was a real good support to us, which, you know, as parents, you're going: "What the hell do you do?"

I couldn't handle my kids, finances, housework, cooking, shopping ... I couldn't take care of anything. ... [Case management] pretty much was the only thing holding my family together.

Ten children had been involved in what community mental health centers referred to as "psycho-social groups." Generally, these groups set out to further children's social skills in a group treatment format along with other goals specified in children's individual treatment plans. According to family respondents, their children's participation in these groups was overall a good experience in that groups provided families with some respite and children with structured time. In some cases, however, disruptive child behaviors in groups led to removal or suspension of the child from the group, leaving parents confused about the usefulness of the group.

They had an incident where he was a bit out of control, and he banged his face on the floor, made his nose bleed. They suspended him for a day ... he is going there to get help with his behavior and when he shows the behavior, they suspend him. What good is that? So I took him out of that.

Families indicated that there was generally good rapport with most therapists. They were also generally satisfied with attendant care services, a one-on-one support designed to maintain children with SED in their communities, in that their children liked providers and activities. Still, families also noted limited availability, access to, and continuity of attendant care providers. In nine cases, respondents mentioned being involved in wraparound services and at least one family specifically called a meeting in response to critical behaviors. Four families indicated that parent support groups and family training on concrete behavioral interventions would have been useful. Three children went to licensed foster homes for respite care and had a generally positive experience, and three respondents conveyed a need for accessible respite care for children who are not in state custody.

Interviews reflected a wide array of perspectives on the quality of involved child welfare services ranging from highly satisfied to very unsatisfied.

I always felt like I could call them [child welfare agency] and ask them questions, or if there was a problem at school, they would be the first people I'd call.

It was just a nightmare trying to get a hold of anybody. And they change hands so often there that nobody knew what was going on.

Families described the quality of relationships with schools as either highly supportive or quite contentious. Parents were concerned about the frequent use of seclusion, a lack of options for different classrooms, and difficulties getting evaluations and IEPs done in a timely manner.

This classroom is not working for her. [We] tried getting her into a different classroom ... They said it was not a good fit and that maybe we would have more options next year. I don't feel like we can wait that long. She needs to be in a place where they acknowledge her strengths. I feel like no one is listening to me.

Even in supportive parent-school relationships, families frequently voiced concerns about teachers and paraeducators being overwhelmed, and lacking appropriate training.

The poor teachers, they don't have any training for kids that are ADHD, ODD, OCD. They don't have any training for that. None whatsoever. ...I think that's probably one of our biggest complaints.

Common barriers affecting service quality in mental health, child welfare, and school systems alike included a lack of available or accessible services at critical points in children's lives, the lack of communication and collaboration within and between service systems, families' difficulties with transportation and financial resources, and a sense of not being taken seriously. In addition, turnover complicated or delayed crucial communication with families and across systems, and constituted a loss of support and stability for families and children.

It's hard because ... as parents, we don't take change well. We have enough change as it is. So we don't take change well.

I was trying to get him into the mental health center ... he had an appointment. And then a few days before his appointment, they told me that person had been let go. They would have to reschedule another appointment. Well, you can't just reschedule in a couple of days. They make it another month. And by this time, he was out of control again.

Discussion and Implications

This study supports an ecological understanding of children's mental health emergencies and adds new aspects to the existing knowledge base. Consistent with the literature, a psychiatric crisis for children in this study was determined by challenging behaviors that posed a serious risk to the child or others, combined with a family's acute sense of not being able to keep the child or others safe

with available resources. Families' capacity to manage challenging child behaviors was impacted by other stressors in their lives such as major life changes, losses, and transitions, as well as the level of chronic challenges such as poverty or a history of psychiatric difficulties in the family.

Families' sense of helplessness was exacerbated when resources were unavailable, inaccessible, ill-coordinated, or not perceived as helpful by families. The absence of consistent communication and collaboration between families and providers or between various service systems left families frustrated. Conversely, families appreciated quick access to familiar mental health providers, feeling like they were being taken seriously and receiving concrete information about what to do or try. Specifically, difficulties with medication management and insufficient or conflicting information about medications contributed to families' sense of crisis and the subsequent need to hospitalize the child, an aspect that has not been highlighted in previous studies.

Implications for community-based crisis services fall into two main areas: (1) the prevention of acute crises by assuring timely access to a wide array of quality community-based services, including a specific need for accessible and reliable management of psychiatric medication, and (2) the need for a child- and family-centered crisis response system that modifies hotline services and adds attention to transportation issues.

Crisis Prevention Through Access to an Array of Quality Community-Based Services

A full range of available, accessible, quality community-based services can assist families in preventing or de-escalating crisis situations. When faced with a crisis, families turn to those mental health providers with whom they have an existing positive relationship. Turnover, miscommunication, strained relations with families, or a lack of communication and collaboration between various providers not only pose barriers to effective services, but can in effect contribute to the development of crisis situations in a manner consistent with "system-induced" crises described by Petr (1994).

The study underscores the central role of case managers, who serve as a nexus of mental health services in that they ease access to other services, communicate with families, and collaborate with other providers including educators or child welfare workers. The effectiveness of case management is limited when other supports, such as attendant care, respite, or parent support are not available or accessible at critical points. With an ecological understanding of crises, providers are able to anticipate an escalation of difficulties in the wake of life changes or transitions. If providers have existing and positive relationships with families, they can maximize supports in response to or anticipation of transitions such as moving, changes in schools, losses in the family, or losses of providers that will likely diminish the capacity of families to manage challenging child behaviors.

To be useful instruments for prevention or de-escalation of crises, crisis plans need to provide updated, specific, and individualized steps for families, school personnel, and other providers beyond standard items like “call the hotline” or “call the police.” Given that children’s behaviors in schools were frequently part of the crisis situation, educators should be active participants in the development of a crisis plan. Effective and ongoing communication and collaboration between mental health and education providers, as well as training and assistance for educators, is essential to curtail crises and help children be maintained in the least restrictive environments.

Families’ confusion and anxiety during a crisis may be lessened if they received pertinent information about screening and admission procedures, as well as policies specific to children in custody, *prior to* the advent of crises. Having advance and accurate information in verbal and written form could empower families to be active and knowledgeable participants in an often confusing screening and admission process.

An added focal area not previously identified in the literature is the specific need to improve medication management and the availability and accessibility of psychiatric services for children. While medications were generally viewed as necessary and helpful by families, medication management was also among the most frequently cited concerns and reasons for admission to hospitals. Families desire and deserve adequate management of medications and side effects on an outpatient basis, timely access to psychiatric consults, accurate and reliable information about medications, and being taken seriously by psychiatrists.

Child- and Family-Centered Crisis Response

Crisis services need to be responsive to the particular needs of families and children that are different from adult crisis services. Effective crisis response for children requires staff trained in crisis intervention and experienced in working with children and families. This combination of experiences includes such skills as the ability to apply an ecological view and strengths-based approaches in assessment and intervention and the ability to successfully de-escalate children and families to preclude more drastic measures.

Relying on or deferring to law enforcement as a crisis response service is an insufficient practice to assist children and families in mental health crises. Police officers can be a valuable resource to help keep children and providers safe but too often officers are unprepared and not trained to deal with children in mental health crises. Thus, there is a need to foster collaborations between law enforcement and mental health providers to maximize efficient and appropriate use of law enforcement personnel.

To ease the often lengthy screening and admission process for families, timely communication between various providers, systems, and families is needed. For children in state custody, clarity of procedural policies between men-

tal health and child welfare staff could shorten waiting periods and frustrations for families who are already exhausted at the time.

Adding to existing knowledge, this study indicates that transportation and modified hotline services are important areas to address to assist families in crises. First, mobile crisis teams need to be able and willing to meet families in their homes. While concerns about provider safety are legitimate and need to be addressed, the practice of asking families to somehow transport an out-of-control child from their home to an agency setting places undue burden on already stressed families. Having families call the police to intervene or provide transportation may be legitimate in some cases but cannot replace the need for having mobile mental health provider teams willing and able to go to family residences to assist in times of crisis.

Collaborations with law enforcement or the development of joint mental health and law enforcement teams may provide one avenue to meet families’ needs and concerns about provider safety. The ability to conduct screenings in families’ homes, or transport children safely with the assistance of mobile crises responders, could also minimize the use of emergency rooms for crisis assistance and screenings.

Second, a revised understanding of what constitutes a crisis for families, and broadening definitions of crisis beyond suicidal or homicidal behaviors would allow hotline service to be more child- and family-centered. Since hotline services are often geared toward helping adults in crises, responders are frequently unprepared to offer specific, hands-on advice to parents on how to deal with children’s behaviors. Changes could lead to the creation of *warm-lines*—hotlines designed to specifically address the needs of families in crises that also offer hands-on coaching. In the absence of family-centered definitions and training, responders are likely to revert to rote advice, such as “call back during business hours” or “call the police,” leaving families feeling more helpless.

Limitations

Limitations of this study include the small size and nature of the sample. This study reports the insights and perspectives of family members whose young children experienced admission to a state mental hospital. The sample does not include families whose children were successfully diverted from hospitalization. Indeed, community-based services for young children in psychiatric crisis may have worked well for most young children and their families in the state, as implied in the reduction of admissions of children 12 years old and under to state hospitals from 148 children in 2002 to 92 children in 2004. Additionally, while families identified areas for improving crisis and community-based services, none of the respondents indicated directly that such improvements would or could have prevented the need for hospitalization. These young children, who had

multiple, severe, and chronic mental health issues, represent the population that presents the greatest challenges to community-based and crisis personnel.

Conclusion

Adding families' perspectives to the evolving empirical and conceptual knowledge base, this study contributes to a richer understanding of what constitutes best practices (Petr & Walter, 2005) for children and families in serious psychiatric crises. Results not only support an ecological understanding of child mental health emergencies, but specify the need for the development of a more family-centered crisis response. To prevent or curtail crises, families need timely access to the full range of quality community-based services, including adequate medication management, secure transportation, and warm-line services.

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